

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 006218	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2014
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL- INDIANAPOLIS SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was an investigation for a State hospital complaint.</p> <p>Complaint: #IN00140203 Substantiated: No deficiencies related to the allegations are cited.</p> <p>Facility Number: 006218</p> <p>Survey Date: 04/15/2014</p> <p>Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Kindred Hospital- Indianapolis South is in compliance with 410 IAC 15-1.5-5, Physician services and 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 04/24/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE